TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred Senate Bill No. 285 entitled "An act relating to health care reform initiatives, data collection, and access to home- and community-based services" respectfully reports that it has considered the same and recommends that the House propose to the Senate that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * Payment and Delivery System Reform; Appropriations * * *

Sec. 1. DEVELOPMENT OF PROPOSAL FOR SUBSEQUENT ALL-PAYER MODEL AGREEMENT

(a)(1) The Director of Health Care Reform in the Agency of Human Services, in collaboration with the Green Mountain Care Board, shall develop a proposal for a subsequent agreement with the Center for Medicare and Medicaid Innovation to secure Medicare's sustained participation in multi-payer alternative payment models in Vermont. In developing the proposal, the Director shall consider:

(A) total cost of care targets;

(B) global payment models;

(C) strategies and investments to strengthen access to:

(i) primary care;

(ii) home- and community-based services;

(iii) subacute services;

(iv) long-term care services; and

(v) mental health and substance use disorder treatment services; and

(D) strategies and investments to address health inequities and social determinants of health.

(2)(A) The development of the proposal shall include consideration of alternative payment and delivery system approaches for hospital services and community-based providers such as primary care providers, mental health providers, substance use disorder treatment providers, skilled nursing facilities, home health agencies, and providers of long-term services and supports.

(B) The alternative payment models to be explored shall include, at a minimum:

(i) value-based payments for hospitals, including global payments, that take into consideration the sustainability of Vermont's hospitals and the State's rural nature, as set forth in subdivision (b)(1) of this section;

(ii) geographically or regionally based global budgets for health care services;

(iii) existing federal value-based payment models; and

(iv) broader total cost of care and risk-sharing models to address patient migration patterns across systems of care.

(C) The proposal shall:

(i) include appropriate mechanisms to convert fee-for-service reimbursements to predictable payments for multiple provider types, including those described in subdivision (A) of this subdivision (2);

(ii) include a process to ensure reasonable and adequate rates of payment and a reasonable and predictable schedule for rate updates;

(iii) meaningfully impact health equity and address inequities in terms of access, quality, and health outcomes; and

(iv) support equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care as part of an integrated, holistic system of care.

(3)(A) The Director of Health Care Reform, in collaboration with the Green Mountain Care Board, shall ensure that the process for developing the proposal includes opportunities for meaningful participation by the full continuum of health care and social service providers, payers, and other interested stakeholders in all stages of the proposal's development.

(B) The Director shall seek to minimize the administrative burden of and duplicative processes for stakeholder input.

(C) To promote engagement with diverse stakeholders and ensure the prioritization of health equity, the process may utilize existing local and regional forums, including those supported by the Agency of Human Services.

(b) As set forth in subdivision (a)(2)(B)(i) of this section and notwithstanding any provision of 18 V.S.A. § 9375(b)(1) to the contrary, the Green Mountain Care Board shall:

(1) in collaboration with the Agency of Human Services and using the stakeholder process described in subsection (a) of this section, build on successful health care delivery system reform efforts by developing value-based payments, including global payments, from all payers to Vermont hospitals or accountable care organizations, or both, that will:

(A) help move the hospitals away from a fee-for-service model;

(B) provide hospitals with predictable, sustainable funding that is aligned across multiple payers, consistent with the principles set forth in 18 V.S.A. § 9371, and sufficient to enable the hospitals to deliver high-quality, affordable health care services to patients;

(C) take into consideration the necessary costs and operating expenses of providing services and not be based solely on historical charges; and

(D) take into consideration Vermont's rural nature, including that many areas of the State are remote and sparsely populated;

(2) determine how best to incorporate value-based payments, including global payments to hospitals or accountable care organizations, or both, into the Board's hospital budget review, accountable care organization certification

and budget review, and other regulatory processes, including assessing the impacts of regulatory processes on the financial sustainability of Vermont hospitals and identifying potential opportunities to use regulatory processes to improve hospitals' financial health; and

(3) recommend a methodology for determining the allowable rate of growth in Vermont hospital budgets, which may include the use of national and regional indicators of growth in the health care economy and other appropriate benchmarks, such as the Hospital Producer Price Index, Medical Consumer Price Index, bond-rating metrics, and labor cost indicators, as well as other metrics that incorporate differentials as appropriate to reflect the unique needs of hospitals in highly rural and sparsely populated areas of the State.

(c) On or before January 15, 2023, the Director of Health Care Reform and the Green Mountain Care Board shall each report on their activities pursuant to this section to the House Committees on Health Care and on Human Services and the Senate Committees on Health and Welfare and on Finance.

Sec. 2. HOSPITAL SYSTEM TRANSFORMATION; PLAN FOR ENGAGEMENT PROCESS; REPORT

(a) The Green Mountain Care Board shall develop a plan for a data-informed, patient-focused, community-inclusive engagement process for Vermont's hospitals to reduce inefficiencies, lower costs, improve population

health outcomes, reduce health inequities, and increase access to essential services while maintaining sufficient capacity for emergency management.

(b) The plan for the engagement process shall include:

(1) which organization or agency will lead the engagement process;

(2) a timeline that shows the engagement process occurring after the development of the all-payer model proposal as set forth in Sec. 1 of this act;

(3) how to hear from and share data, information, trends, and insights with communities about the current and future states of the hospital delivery system, unmet health care as identified through the community health needs assessment, and opportunities and resources necessary to address those needs; and

(4) a description of the opportunities to be provided for meaningful participation in all stages of the process by employers; consumers; health care professionals and health care providers, including those providing primary care services; Vermonters who have direct experience with all aspects of Vermont's health care system; and Vermonters who are diverse with respect to race, income, age, and disability status;

(5) a description of the data, information, and analysis necessary to support the process, including information and trends relating to the current and future states of the health care delivery system in each hospital service area, the effects of the hospitals in neighboring states on the health care

services delivered in Vermont, the potential impacts of hospital system transformation on Vermont's nonhospital health care and social service providers, the workforce challenges in the health care and human services systems, and the impacts of the pandemic;

(6) how to assess the impact of any changes to hospital services on nonhospital providers, including on workforce recruitment and retention;

(7) the amount of the additional appropriations needed to support the engagement process; and

(8) a process for determining the amount of resources that will be needed to support hospitals in implementing the transformation initiatives to be developed as a result of the engagement process.

(c) On or before January 15, 2023, the Green Mountain Care Board shall report on its activities pursuant to this section to the House Committees on Health Care and on Human Services and the Senate Committees on Health and Welfare and on Finance.

Sec. 3. PAYMENT AND DELIVERY SYSTEM REFORM; APPROPRIATIONS

(a) The sum of $1,400,000.00 is appropriated from the General Fund to the Agency of Human Services in fiscal year 2023 to support the work of the Director of Health Care Reform as set forth in Sec. 1 of this act.

(b) The sum of $3,600,000.00 is appropriated from the General Fund to the Green Mountain Care Board in fiscal year 2023 to support the work of the Board as set forth in Sec. 1 of this act.

* * * Health Care Data * * *

Sec. 4. HEALTH INFORMATION EXCHANGE STEERING COMMITTEE; DATA STRATEGY

The Health Information Exchange (HIE) Steering Committee shall continue its work to create one health record for each person that integrates data types to include health care claims data; clinical, mental health, and substance use disorder services data; and social determinants of health data. In furtherance of these goals, the HIE Steering Committee shall include a data integration strategy in its 2023 HIE Strategic Plan to merge and consolidate claims data in the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) with the clinical data in the HIE.

Sec. 5. 18 V.S.A. § 9410 is amended to read:

§ 9410. HEALTH CARE DATABASE

(a)(1) The Board shall establish and maintain a unified health care database to enable the Board to carry out its duties under this chapter, chapter 220 of this title, and Title 8, including:

(A) determining the capacity and distribution of existing resources;

(B) identifying health care needs and informing health care policy;

(C) evaluating the effectiveness of intervention programs on improving patient outcomes;

(D) comparing costs between various treatment settings and approaches;

(E) providing information to consumers and purchasers of health care; and

(F) improving the quality and affordability of patient health care and health care coverage.

(2) [Repealed.]

(b) The database shall contain unique patient and provider identifiers and a uniform coding system~~,~~ and shall reflect all health care utilization, costs, and resources in this State~~,~~ and health care utilization and costs for services provided to Vermont residents in another state.

* * *

(e) ~~Records or information protected by the provisions of the physician-patient privilege under 12 V.S.A. § 1612(a), or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the protected person.~~ [Repealed.]

(f) The Board shall adopt a confidentiality code to ensure that information obtained under this section is handled in an ethical manner.

* * *

(h)(1) All health insurers shall electronically provide to the Board in accordance with standards and procedures adopted by the Board by rule:

(A) their health insurance claims data, provided that the Board may exempt from all or a portion of the filing requirements of this subsection data reflecting utilization and costs for services provided in this State to residents of other states;

(B) cross-matched claims data on requested members, subscribers, or policyholders; and

(C) member, subscriber, or policyholder information necessary to determine ~~third party~~ third-party liability for benefits provided.

(2) The collection, storage, and release of health care data and statistical information that are subject to the federal requirements of the Health Insurance Portability and Accountability Act (HIPAA) shall be governed exclusively by the regulations adopted thereunder in 45 C.F.R. Parts 160 and 164.

* * *

(3)(A) The Board shall collaborate with the Agency of Human Services and participants in the Agency's initiatives in the development of a comprehensive health care information system. The collaboration is intended to address the formulation of a description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of limited-use data sets, the criteria and

procedures to ensure that HIPAA compliant limited-use data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system.

(B) To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in Vermont. In presenting data for public access, comparative considerations shall be made regarding geography, demographics, general economic factors, and institutional size.

(C) Consistent with the dictates of HIPAA, and subject to such terms and conditions as the Board may prescribe by rule, the Vermont Program for Quality in Health Care shall have access to the unified health care database for use in improving the quality of health care services in Vermont. In using the database, the Vermont Program for Quality in Health Care shall agree to abide by the rules and procedures established by the Board for access to the data. The Board's rules may limit access to the database to limited-use sets of data as necessary to carry out the purposes of this section.

(D) Notwithstanding HIPAA or any other provision of law, the comprehensive health care information system shall not publicly disclose any data that contain direct personal identifiers. For the purposes of this section, "direct personal identifiers" include information relating to an individual that

contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number.

* * *

* * * Blueprint for Health * * *

Sec. 6. 18 V.S.A. § 702(d) is amended to read:

(d) The Blueprint for Health shall include the following initiatives:

* * *

(8) The use of quality improvement facilitation and other means to support quality improvement activities, including using integrated clinical and claims data, where available, to evaluate patient outcomes and promoting best practices regarding patient referrals and care distribution between primary and specialty care.

Sec. 7. BLUEPRINT FOR HEALTH; COMMUNITY HEALTH TEAMS; QUALITY IMPROVEMENT FACILITATION; REPORT

On or before January 15, 2023, the Director of Health Care Reform in the Agency of Human Services shall recommend to the House Committees on Health Care and on Appropriations and the Senate Committees on Health and Welfare, on Appropriations, and on Finance the amounts by which health insurers and Vermont Medicaid should increase the amount of the per-person, per month payments they make toward the shared costs of operating the Blueprint for Health community health teams and providing quality

improvement facilitation, in furtherance of the goal of providing additional resources necessary for delivery of comprehensive primary care services to Vermonters and to sustain access to primary care services in Vermont. The Agency shall also provide an estimate of the State funding that would be needed to support the increase for Medicaid, both with and without federal financial participation.

* * * Options for Extending Moderate Needs Supports * * *

Sec. 8. OPTIONS FOR EXTENDING MODERATE NEEDS SUPPORTS; WORKING GROUP; GLOBAL COMMITMENT WAIVER; REPORT

(a) As part of developing the Vermont Action Plan for Aging Well as required by 2020 Acts and Resolves No. 156, Sec. 3, the Department of Disabilities, Aging, and Independent Living shall convene a working group comprising representatives of older Vermonters, home- and community-based service providers, the Office of the Long-Term Care Ombudsman, the Agency of Human Services, and other interested stakeholders to consider extending access to long-term home- and community-based services and supports to a broader cohort of Vermonters who would benefit from them, and their family caregivers, including:

(1) the types of services, such as those addressing activities of daily living, falls prevention, social isolation, medication management, and case management that many older Vermonters need but for which many older

Vermonters may not be financially eligible or that are not covered under many standard health insurance plans;

(2) the most promising opportunities to extend supports to additional Vermonters, such as expanding the use of flexible funding options that enable beneficiaries and their families to manage their own services and caregivers within a defined budget and allowing case management to be provided to beneficiaries who do not require other services;

(3) how to set clinical and financial eligibility criteria for the extended supports, including ways to avoid requiring applicants to spend down their assets in order to qualify;

(4) how to fund the extended supports, including identifying the options with the greatest potential for federal financial participation;

(5) how to proactively identify Vermonters across all payers who have the greatest need for extended supports;

(6) how best to support family caregivers, such as through training, respite, home modifications, payments for services, and other methods; and

(7) the feasibility of extending access to long-term home- and community-based services and supports and the impact on existing services.

(b) The working group shall also make recommendations regarding changes to service delivery for persons who are dually eligible for Medicaid

and Medicare in order to improve care, expand options, and reduce unnecessary cost shifting and duplication.

(c) On or before January 15, 2024, the Department shall report to the House Committees on Human Services, on Health Care, and on Appropriations and the Senate Committees on Health and Welfare and on Appropriations regarding the working group's findings and recommendations, including its recommendations regarding service delivery for dually eligible individuals, and an estimate of any funding that would be needed to implement the working group's recommendations.

(d) If so directed by the General Assembly, the Department shall collaborate with others in the Agency of Human Services as needed in order to incorporate the working group's recommendations on extending access to long-term home- and community-based services and supports as an amendment to the Global Commitment to Health Section 1115 demonstration in effect in 2024 or into the Agency's proposals to and negotiations with the Centers for Medicare and Medicaid Services for the iteration of Vermont's Global Commitment to Health Section 1115 demonstration that will take effect following the expiration of the demonstration currently under negotiation.

* * * Summaries of Green Mountain Care Board Reports * * *

Sec. 9. 18 V.S.A. § 9375 is amended to read:

§ 9375. DUTIES

* * *

(e)(1) The Board shall summarize and synthesize the key findings and recommendations from reports prepared by and for the Board, including its expenditure analyses and focused studies. The Board shall develop, in consultation with the Office of the Health Care Advocate, a standard for creating plain language summaries that the public can easily use and understand.

(2) All reports and summaries prepared by the Board shall be available to the public and shall be posted on the Board's website.

* * * Primary Care Providers; Medicaid Reimbursement Rates * * *

Sec. 10. MEDICAID REIMBURSEMENT RATES; PRIMARY CARE AT 100 PERCENT OF MEDICARE FISCAL YEAR 2024

It is the intent of the General Assembly that Vermont's health care system should reimburse all Medicaid participating providers at rates that are equal to 100 percent of the Medicare rates for the services provided, with first priority for primary care providers. In support of this goal, in its fiscal year 2024 budget proposal, the Department of Vermont Health Access shall either provide reimbursement rates for Medicaid participating providers for primary

care services at rates that are equal to 100 percent of the Medicare rates for the services or, in accordance with 32 V.S.A. § 307(d)(6), provide information on the additional amounts that would be necessary to achieve full reimbursement parity for primary care services with the Medicare rates.

* * * Prior Authorizations * * *

Sec. 11. DEPARTMENT OF FINANCIAL REGULATION; GREEN MOUNTAIN CARE BOARD; PRIOR AUTHORIZATIONS; ADMINISTRATIVE COST REDUCTION; REPORT

(a) The Department of Financial Regulation shall explore the feasibility of requiring health insurers and their prior authorization vendors to access clinical data from the Vermont Health Information Exchange whenever possible to support prior authorization requests in situations in which a request cannot be automatically approved.

(b) The Department of Financial Regulation shall direct health insurers to provide prior authorization information to the Department in a format required by the Department in order to enable the Department to analyze opportunities to align and streamline prior authorization request processes. The Department shall share its findings and recommendations with the Green Mountain Care Board, and the Department and the Board shall collaborate to provide recommendations to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance on or before January 15,

2023 regarding the statutory changes necessary to align and streamline prior authorization processes and requirements across health insurers.

* * * Effective Dates * * *

Sec. 12. EFFECTIVE DATES

(a) Sec. 3 (payment and delivery system reform; appropriations) shall take effect on July 1, 2022.

(b) The remainder of this act shall take effect on passage.

(Committee vote: _____)

_____

Representative _____

FOR THE COMMITTEE